Safeguarding Adults in Brent

Leocardo (Also referred to as Adult E) Safeguarding Adults Review

Independent Reviewer: Fran Pearson

Introduction

Why this Review was commissioned

Int.1 Leocardo was a sociable and energetic man from the African-Caribbean community. He had worked for London Underground after moving to the UK from Trinidad in 1961. He was rooted in one part of Brent where he had lived for 40 years before being diagnosed with Lewy Body dementia in late 2012. The combination of declining memory, but being unusually fit and active for someone in their 80s, were the two central risks for Leocardo. These risks were well understood by his two daughters, who had Lasting Power of Attorney for Finance, and for Health and Welfare.

Int.2 Leocardo became increasingly at risk in his home of 40 years and in 2015, in response to consensus about risk between Leocardo's daughters and his professional network at the time, it was agreed he would move to a different sort of housing, with the aim of reducing this risk. This was extra care sheltered housing. The most recent inspection report of the scheme Leocardo moved to, described what extra care housing typically consists of:

> *This scheme provides care and support to older people and people with mental health needs living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. [The extra care scheme] in Brent is a purpose-built block of flats on three levels, containing 40 flats. People remain independent and live in their own flat within their community. People's care and housing are provided under separate contractual agreements.*

Int.3 The recurrent and extremely concerning risk for Leocardo was that of leaving his home and going missing. Following his move to new accommodation this continued. Police data provided to the Interim SAR and the inquest suggest he went missing in excess of 20 times from the extra care scheme. Professional activity and actions by Leocardo's daughters concentrated on responding to,

and reducing the likelihood of, these missing episodes, and for periods had an impact. It seems from CCTV footage that Leocardo left the scheme at approximately 18:00 hours on 3rd August 2017 for the final time. He was not carrying his keys with a tracker which was one of the pieces of technology provided by professionals in response to risk. Very sadly, Leocardo's body was found on 14th October 2017.

Where this report fits in a process that has included an inquest

Int.4 This report concludes a process begun in 2018. The Coroner had requested an interim SAR, which was completed during October 2019, ahead of the November 2019 inquest into Leocardo's tragic death. At the inquest, the coroner drew a narrative conclusion from the evidence he heard.

> *"[Leocardo] died at some point between 3 August 2017 and 14 October 2017. He had wandered from his Extra Care accommodation on the night of 3 August 2017. His body was found in a dip underneath a hedge……. There were serious failings in the care provided by social services."*

The aim of this report, and how it is set out

Int.5 The aim of this SAR is to provide independent advice to the Brent SAB on how to take forward the seven lines of enquiry that were in the interim SAR. However, without waiting, the SAB commissioned three assurance audits on issues that emerged during the inquest and immediately after. Two of the audits are summarised in this report.

Int.6 The interim SAR drew on specific and limited information. This final report uses data released to Brent Safeguarding Adults Board following the inquest, along with other relevant data, either in the public domain, or requested in order to support the conclusions and recommendations.

Int.7 The report has two sections.

Section One:

The seven overarching questions developed for the interim SAR: *Using the documents released to the Brent Safeguarding Adults Board what systems conclusions can be reached for each of those seven questions?*

Section Two:

Recommendations on multi-agency safeguarding that Brent SAB can test out for assurance.

Int.8 Sources of data

Three published Care Quality Commission Reports on the scheme, all referenced during the inquest (CQC 2017; CQC 2018; and CQC 2019[1])

Inspected	Published	Rating
28th November 2018	16th March 2019	Requires Improvement
27th November 2017	12th May 2018	Requires Improvement
4th July 2017	12th August 2017	Requires Improvement

A transcript of the inquest;

A witness statement made by the Head of Complex Care at Brent Council for the inquest;

An internal assurance report from Head of Complex Care to the relevant Lead Member at Brent Council;

A further response from Brent Council provided in July 2020 – comments on the first draft of this report;

Three audits commissioned by Brent Safeguarding Adults' Board;

Information from two other London boroughs about their approach to Community Deprivation of Liberty Safeguards (DoLS);

Information in the public domain which is listed in the 'References' section.

Moving from case-specific to system-wide assurance:

Int.9 The lines of enquiry in the interim SAR focused on case specific data about Leocardo, as this was all that was available at the time. Using the sources of data listed above I have drawn conclusions about the safety of the multi-agency safeguarding system in Brent, and I have stated the extent to which I have been able to do this. By asking for assurance about the wider system of safety for adults with dementia in extra care housing in Brent, the Safeguarding Adults Board can test out if there is sufficient and effective work under way to reduce the likelihood of what happened to Leocardo happening to someone else in need of protection. Not only is this one of the things that the Care and Support Statutory Guidance says Safeguarding Adults Reviews should achieve. It was a point of principle for Leocardo's daughters as well, that other families should be spared their experience.

[1] The care provider stated that since The CQC Report on the extra care scheme in Brent was published in 2019, it has made a number of changes and introduced measures to keep residents safe.

Int.10 The recommendations are intended to help the Brent Safeguarding Adults Board follow up on the effectiveness of multi-agency safeguarding systems.

Original Terms of Reference for this Review – implications of the inquest

Int.11 Although new information emerged during the inquest, it was all in the areas identified in the Interim SAR. The seven overarching questions therefore remain the relevant questions for Brent SAB to pursue, and all material is organised underneath them.

Section One – returning to the overarching questions for this Safeguarding Adults Review

1.

How well does the local safeguarding system respond to the needs of adults whose risk and vulnerability is increasing? Where possible comment on the effectiveness of Reactive systems, for example: MERLINs, Safeguarding Referrals, Missing Person alerts and Proactive systems, for example: contract monitoring and care reviews.

Summary of the systems issues:

A test of any multi agency safeguarding system is how well it is set up to deal with increasing risk and vulnerability. Proactive and reactive systems should both be in place, owned and agreed as an approach by senior leaders, and any gaps acknowledged. The inquest transcript and the other data for this SAR provide some assurance on adults currently in extra care housing but without a sense of the wider strategy.

1.1 The Metropolitan Police Force is hampered in its ability to respond to adults with dementia who go missing, because according to witnesses' accounts to the Coroner, its Computer Aided Dispatch system relies on individual call handlers to link missing episodes. Individuals like Leocardo are more at risk because repeated patterns of going missing, and reports on any regular places where they have been found in the past, are not all linked in order to inform the next officer on the scene. The London Safeguarding Adults Procedures (ADASS 2019) contains the word 'missing' only once, in a very different context - that of honour-based violence. The Met Police monthly Safeguarding Adults Report data shared with Safeguarding Adults Boards and broken down by borough is focused on mental health and reports of abuse and neglect. It does not cover adults with care and support needs who go missing. This is picked up as an issue for Brent SAB to raise at a London-wide level.

1.2 For the family there was a particular issue that was outside of the scope of the Inquest but Brent SAB set out to respond to as part of this review. This was the insensitive handling of the discovery of Leocardo's body in London Borough of Hillingdon by the section of the Metropolitan Police, the West Borough Operational Command Unit for Ealing, Hillingdon and Hounslow. This "BOCU" arrangement covering two or three London boroughs was part of a restructure that took place in the Met after Leocardo's death, so it is not possible to go back to exactly the same team that responded in 2017. The statement to the Coroner by Leocardo's daughter set out unequivocally the impact this had on the family. This is picked up in the appendix on single agency actions.

1.3 As far as the idea of a reactive system comprised of Police 'Adult Come to Notice' reports (MERLINs), safeguarding referrals, and missing person alerts, that responds to adults with dementia going missing, the three data sources did not indicate how those elements join up. Evidence to the inquest was a protocol existed specifically for Leocardo when he went missing. However, it was clearly ineffective with the care provider manager suggesting it broke down because the police would no longer go searching for Leocardo, and the police noting accurately that the care provider did not anyway always notify them when Leocardo went missing[2].

1.4 The Coroner was highly critical of the local authority for not being proactively responsive to the care provider. Additionally, the lack of contract and quality reviews for extra care was another area the Coroner found wanting. The inquest highlighted that there is a responsibility for care providers in extra care housing schemes to be proactive in contacting not just social work or safeguarding but their nominated link in commissioning. The care provider was slightly criticised for not escalating their concerns about Leocardo sufficiently. Some aspects of this are picked up in section 6 about the role of the regulator. The evidence from the Head of Complex Care to the inquest and the follow-on report to the Lead Member at Brent Council indicated an intention to clarify the ways for providers to contact the relevant contracts team at the Council. This is not the same as setting out to make systems more proactive. "All providers have been reminded that, as part of their responsibility to alert us when there is an issue of escalating risk with an individual [sequence then set out]. Providers have been told that for urgent issues they should receive a response the same day, and that if they do not they should follow the escalation protocols".

[2] The care provider was commissioned to provide support to residents but this is not 24 hour care and residents cannot be physically prevented from leaving the building by staff employed by the care provider. In addition, on some occasions due to technology failing, the care provider was not aware that Leocardo had gone missing.

1.5 “Another key change is that people who have been placed in [Extra Care Housing] by a social worker would not be managed by a social worker from the Complex Care Team now, they would instead have a [Placement Relationship Officer] who the providers know as they are the named worker for all individuals in that home or scheme”. Again, this is an intention about a new process and the SAB could ask how well it is working, given that professionals with a different role and training are now responsible for being part of that reciprocal relationship with care providers to pick up risk.

1.6 At the inquest there was discussion of hours allocated to Leocardo’s care package, by the local authority based on assessed need to occupy him with the goal of reducing his walking out of the scheme. The Head of Complex Care, not at the inquest but in the subsequent report to the Lead Member at Brent Council said “a pilot scheme was agreed to support individuals with challenging behaviours to access the community through employing a Community Access worker”. This is a welcome initiative which falls into the area of multi-agency working and which the SAB could seek assurance on.

1.7 The Coroner criticised a backlog at the Council which meant Leocardo’s case was not picked up when his allocated worker went on extended leave, social work caseloads, and handover arrangements when a worker goes on leave. The Council’s response, immediately after Leocardo’s death and outlined to the coroner, was to see these issues in the context of a wider internal system where oversight of social work practice and a culture which supported high quality social work, had to be addressed. The reports provided to help with compiling this Safeguarding Adults Review give examples of the work that has been underway. There is a recommendation for the Brent SAB on what sort of assurance it might seek from the Council on this work, and the SAB has already begun to gather this data within the audits outlined at 4.2 to 4.9.

2.

What is the ability of professionals to respond in a timely and proportionate manner that also understands the role of families in these situations? Where possible, comment on the added complexity when family members hold the legal authority to make decisions.

Summary of the systems issues:

The family barrister at the inquest said: '[That Leocardo's daughters] held Power of Attorney is not a factor of relevance when you consider the proper duties upon the local authority". At the inquest, professionals described decision-making about how much risk was acceptable in Leocardo's case as a 'partnership' between his relatives, the care provider, and the local authority. The Coroner was highly critical of this description, and of the local authority for not carrying out its responsibility for keeping Leocardo safe. An effective adult safeguarding system is one where difficult conversations with relatives are acknowledged as part of practice, and where managers make sure that risk is not minimised because it is too difficult to talk about. Where families hold Lasting Power of Attorney, a safe system is one where professionals understand the role of the Court of Protection and use it if appropriate.

2.1 At the inquest, the local authority Head of Complex Care and the social worker last allocated to work with Leocardo, were criticised for getting it wrong in not prioritising Leocardo's safety above the consensus of all involved in his care, including his daughters, that he liked living at the extra care scheme, and for not taking sufficiently urgent or robust steps to make him safe.

2.2 This is a complex area of professional practice, that does not feature in Safeguarding Adults Reviews. Only one SAR – from E Sussex SAB in 2017 – covers it. That review has a very different context to that of Leocardo, and although it analyses sensitivities in working with an Attorney, it is about working with a disengaged Attorney, in sharp contrast to the committed involvement of Leocardo's daughters, so its applicability to Brent is limited.

2.3 Nor does working with family members who hold Power of Attorney appear as a distinct practice issue in the wider context of the core social work skill of having difficult conversations. Using the Court of Protection appropriately is more about technical knowledge. Developing core social work skills is about culture as indicated by the examples from the local authority about improving social work practice. As a result of the Inquest, the local authority's Principle Social Worker (PSW) "reviewed the training to ensure it covers MCA where there is an LPA already in place and a specific training course for social workers addressing LPA and DoLS was commissioned. A further training course addressing LPA and managing tenancy has since been added to the Skills Academy programme." I have included recommendations to cover culture and about knowing what tools to use and reflecting these changes that have already been made.

2.4 Work on Deprivation of Liberty Safeguards should not be solely about equipping professionals, but should equally be about those people with a Power of Attorney having more information on the scope and limitations of their power in relation to Deprivation of Liberty. It is my understanding that Brent SAB has an established relationship with the Office of the Public Guardian. In June 2020 the OPPG launched a partnership programme aimed at working with individuals and / or organisations in some identified localities, to promote attorneyship. The criteria were firstly around families from Black and Ethnic Minority communities and secondly around areas of deprivation. Brent is one of the OPPG's three London 'target' boroughs. This partnership programme, if it were to go ahead, could be a very good opportunity to use OPPG resources and Brent local knowledge to provide information to families in Brent about the scope and limitations of their power in relation to Deprivation of Liberty.

3.

How does the adult safeguarding and care management system in Brent understand, and support the application of, the Mental Capacity Act? What weight is given to this in comparison to all the other competing factors in the system?

Summary of the systems issues:

A safe system for adults with dementia in extra care housing is one in which, when necessary, the local authority as decision maker acts decisively in someone's best interests to move them to a safe setting and secondly has a culture of using Community Deprivation of Liberty Safeguards to respond to risk. In terms of other factors in system which might have had weight, the issue of relatives who are Attorneys was the only other factor which clearly emerged, and this was dealt with in the previous section.

3.1 The Coroner focused on the application of the Mental Capacity Act in relation to Leocardo, criticising the local authority for giving too little weight to Principle 4 of the Mental Capacity Act Code of Practice - *An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.' (section 1(5*)) and instead being too fixed on the notion of the *'least restrictive option' as set out in* Principle 5**:** *'Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.' (section 1(6)) (*Department for Constitutional Affairs 2007). "*Brent Social Services, in my view, were fixated on the need to adopt the least restrictive measures despite frightening evidence to the contrary."*

3.2 The second feature of a safe system for adults with dementia for whom risk is escalating, is a confident culture in the local authority of using the mechanism of Community Deprivation of Liberty Safeguards for people with dementia in extra care housing (https://www.alzheimers.org.uk/get-support/legal-financial/deprivation-liberty-safeguards-dols-supported-living). This includes being clear that the process is not just about authorising restrictive measures but to ensure conversations, assessments and decisions take place to achieve the best outcome for the person. One barrister asserted at the inquest: "Can I say this anecdotally; there are a number of London Boroughs who will not make community Deprivation of Liberty applications. I'm not saying this borough, but there are some boroughs that don't." Two other London boroughs provided information for this SAR. One is at the stage, now suspended due to the coronavirus outbreak, of beginning to explore the current use of DoLS in adults' own homes. The other has developed a methodology to prioritise where risk might most likely reside and estimated numbers of people in the community who may be deprived unlawfully of their liberty according to this methodology. In Brent, activity seems further advanced, with The Operational Director reporting that:

A qualified and experienced social worker has been recruited into the Supported Living Commissioning service (started on the 5th November) specifically to work on community DOLS within Extra Care Schemes and training is being arranged for all staff for community DOLS.

In preparation for the implementation of the new Liberty Protection Safeguards, a review of the DOLS process was commissioned in Jan 2019, and an external consultant supported us to redesign the process and forms on mosaic. This went live with training for all staff in July 2019."

And in a further update in July 2020 stating:

An experienced and qualified Safeguarding Adults Manager is now in a dedicated DoLS oversight post and maintains an overview of the process as well as providing advice and guidance for staff around the DoLS process – used to strengthen the section on DoLs.

3.3 An operational issue and basic expectation of the local authority is that understanding of the Mental Capacity Act leads to assessments being carried out when they need to be. The Coroner said in relation to Brent Council that he *"had heard evidence that mental capacity assessments were not repeated through [Leocardo's stay], best interest decision meetings were not recorded formally and a good part, if not much of the discussions regarding [Leocardo], with and in Brent Social Services, took*

the form of conversations which were not recorded or minuted. I consider this put [Leocardo], and any other resident in a similar position, at risk and it represented repeated missed opportunities to really understand [Leocardo's] position and needs." In assurance reported to the Lead Member after the inquest, the Head of Complex Care stated that:

> *"The need for specific training in MCA and BIA is an ongoing focus and has been in place since early 2018. It was also highlighted in our safeguarding self-assessment and supported by the findings of the peer review, therefore, specific training had already been commissioned. As a result of the Inquest, the Principal Social Worker (PSW) is reviewing the training to ensure it covers MCA where there is an LPA already in place."*

4.

How well do professionals in all relevant settings apply and understand the Mental Capacity Act in LB Brent?

Summary of the systems issues:

A safe system is one where all relevant professionals can apply and understand the Act in order to proactively reduce risk for adults with dementia. The CQC report dated 18th March 2019 noted that in relation to the extra care scheme in Brent, "Although there were elements of good practice in the application of the Mental Capacity Act 2005, this was not across the board. Improvements had been made relating to the use of liberty restricting measures such as location devices, door sensors and the use of verbal distraction techniques. However, decisions about capacity were not consistently taken and reviewed in a structured way. We judged that further improvements were required in this area". Further, the inquest evidence gave an impression of limited understanding by the care provider, confirmed by the regulator who found the provider to be in breach of their legal requirements in relation to Mental Capacity exactly one month before Leocardo went missing for the final time. The only example of good practice where professional who could be said with certainty to have carried out, documented and consulted with the family on a Best Interests Assessment after Leocardo moved to the extra care scheme, was from Leocardo's GP in the context of a specific referral for treatment. However, there was no indication in the material I have seen of other agencies involving the GP in Mental Capacity discussions. A strong system would include this. Initial conclusions about how things have changed for the better can be tentatively drawn from the Brent SAB's independent audits but at the end of the report I have included multi-agency recommendations about this systems issue.

4.1 Overarching question 6, on the role of the regulator, reaches some case-specific conclusions on this same question, covering as it does, the role of the regulator and the care provider.

4.2 The SAB audits: since the inquest the Brent Safeguarding Adults Board has commissioned three audits directly relevant to this SAR. For the first two exercises, an experienced former SAB Business Manager from outside London was asked to audit twenty six extra care housing cases. A third audit by another independent person is underway, examining the quality of casework by the last allocated social worker for Leocardo in Brent, given that the Coroner was extremely concerned about this professional's practice in relation to Leocardo during parts of June and July 2017 when they were his social worker.

4.3 High level summary of the two audits: Between them they covered a total of 26 cases from all seven of Brent's Extra Care Housing Schemes. The independent auditor's summaries are italicised.

4.4 The first audit reflected on the quality of assessment and match of risk to scheme of 20 people placed in the last 12 months – so it gives an indication of whether the concerns from care provider and landlord expressed around Leocardo at the time of his placement are current.

> *The auditor found no major areas of concern, or widespread systemic issues. The audit showed that the correct legal processes are being followed and there was evidence of effective management oversight of cases, as well as some excellent recording by committed practitioners.*

4.5 Positive findings relevant to Leocardo's case

- Some excellent examples of clear, concise, personalised case recording.
- Clear evidence of management oversight of cases recorded in plans and through the Quality Assurance and Monitoring (QAM) process.
- Most cases had a good evidence of rationale for move to Extra Care, often in consultation with family. No recorded evidence was found of family challenging the rationale for a move.

4.6 Areas for improvement relevant to Leocardo's case

- **Personalisation** was lacking in some recording in care plans. Service users wishes and feelings are not always clearly recorded, many didn't 'paint a picture' of the person. The benefits of a move to extra care to the person were not always clearly recorded, particularly in care plan reviews.

- **Extra care checklists inconsistencies and missing documents** – each extra care provider has a checklist for new admissions, as reported to the Inquest. Some however are more detailed than others, and need more rationale set out for decisions around Lasting Power of Attorney (LPA), deputyship, Best Interest Assessment (BIA) cases. 9 of 20 of cases did not have the Extra Care checklist entered onto the local authority's recording system.
- **Extra Care process flowchart** - There is a process flow chart for supported living, but no evidence of a similar process chart for Extra Care. It would be useful to provide this for Extra Care to highlight the differences between this and supported living for practitioners**.** It would outline Extra Care criteria, process for decision making, governance and quality assurance process.

4.7 The second audit took a longer backwards look than the first and covered six cases. It arose directly from the first audit. It sampled "challenging cases", the scope of which included people who were consistently non-compliant with care, verbally or physically aggressive on a regular basis and people who wandered with purpose as a consequence of their dementia. The timeframe was for placements made over twelve months ago.

> *There was no evidence of any systemic issues in the 6 cases audited. There was good evidence of multi-agency involvement to mitigate risks and effective care planning.*
> *The focus of attention should be on the lack of evidence of care plan reviews, particularly where risks are increasing, and safeguarding referrals are being made.*

4.8 Positive findings relevant to Leocardo's case

- Two cases contained excellent examples of clear, concise, case recording,
- All cases contained good evidence of the rationale for the move to Extra Care, with clear evidence of family or advocacy service involvement in decision making.

4.9 Areas for improvement relevant to Leocardo's case

- In one case there was a delay to the scheduled annual care plan review (case 2), where the annual review happened four months after it was due. It was noted that a new Social Worker had been allocated in late December 2019 and tasked to complete the review, however the review was not scheduled until February 2020 and was then further delayed due to coronavirus.

- The care plans and risk assessments should be been reviewed and updated to reflect increased risks, where concerns have been raised by providers (e.g. case 2.) In this case the service user was missing his medication due to his daily routine, and concerns were raised. It needs to be evidenced that these have been addressed. However, there was evidence social workers raised the medication issue with the service user's GP and chemist.

5.

What is the current rationale behind use of either residential care or extra care housing for older people with dementia? In both types of settings, is there learning that could be applied to commissioning of appropriate levels of support for tenants (extra care housing) or: residents (care home settings) that is not static but is dynamic and has implications for everyone who lives in that setting, as well as the professionals providing the services.

Summary of the systems issues:

During the inquest, extra care housing was described as a halfway house for adults with dementia who were too much at risk to be safe in their existing homes but not yet in need of residential care. Beyond description the inquest did not draw out a rationale. However, London Borough of Brent (2018) sets out some of the population data and associated strategy and contains three references to extra care housing suggesting that developing a rationale for using particular types of tenure is imperative.

> *(In Brent) Demographic changes will prompt the need for different housing typologies, increasing the demand for extra care, sheltered housing and leasehold schemes for the Elderly but also increasing the demand for larger family homes. And there will be an increase in the number of elderly people by 2038, 36% of people aged above 65 will be over 81… These demographic changes will prompt the need for different housing typologies, increasing the demand for extra care, sheltered housing and leasehold schemes for the Elderly.*

5.1 An earlier committee report, to the Council’s Community and Wellbeing Scrutiny Committee, in 2016, locates the development of Extra Care Sheltered Housing within the New Accommodation for Independent Living (NAIL) project and sets out the rationale for this initiative and therefore for extra care housing, referencing later in the report the completion of the scheme that Leocardo moved into.

> *[NAIL] is the largest and most strategically important efficiency and quality improvement initiative within the Adult Social Care Department. The programme aims to identify, develop*

and acquire alternative forms of care to residential care for all vulnerable adult client groups in Brent. This is because the outcomes for people going into residential care are not as good as for those people who remain in their own communities.

5.2 What is of interest to this Safeguarding Adults Review is the statement that 'the outcomes for people going into residential care are not as good as for those people who remain in their own communities'. At the inquest, the local authority was criticised for not prioritising Leocardo's safety or taking sufficiently urgent or robust steps to make him safe. Residential care is the safest option for some adults who are at particular forms of risk and although as the inquest heard, there is extra care housing in Brent designed specifically for adults with dementia, a safe system is one where all forms of provision have good outcomes for adults at risk and professionals do not carry any sort of bias against residential care into their practice. It would be unfortunate if this was an unintended consequence of the promotion of extra care. The context of Covid around residential care makes this particularly relevant.

5.3 In terms of learning around the commissioning of dynamic support in extra care or residential settings, the Head of Complex Care's assurances to the Coroner and to the Council's Lead Member after the inquest, included assurance around substantial remodelling of the contracts and commissioning arrangements for adult social care. People who have been placed in extra care housing by a social worker are not managed by a social worker from the Complex Care Team now, they instead have a Placement Review Officer, who is the named worker for all individuals in that home or scheme. Brent SAB could ask more generally how this is working, and specifically how this might be affecting the referrals of safeguarding concerns from extra care housing providers.

6.

Is there any learning in terms of how local organisations work with the regulator (CQC) in supported living / extra care / people receiving care in their own homes?

Summary of the systems issues:

The CQC and local authority along with NHS commissioners for Brent have proactive and regular intelligence-sharing meetings about care providers. These have taken place since 2014 although the CQC inspector provided information that showed there were less regular meetings for a period in 2017. This was, in their view, the result of organisational change at the local authority. Regardless of this, there is another regular meeting between the lead inspector for the wider area of London that Brent is in, the Director of Adult Social Services at the Council, and the Council's Operational Head of

Adult Social Care which has met consistently and is another mechanism for sharing intelligence on risk. The inspector provided confirmation that during 2017 the CQC flagged concerns about Leocardo at a September meeting of the intelligence-sharing group, and throughout 2017 acted upon concerns at the scheme where Leocardo lived, including carrying out inspections there directly arising from concerns about risk to Leocardo. The systems question therefore, and the task for Brent Safeguarding Adults Board, is to understand what factors sometimes prevent follow up on risk, through a mechanism that apparently usually works. If it is solely the case that organisational change caused a period of less effective liaison, then this is resolved. The relevant recommendation sets out the task for Brent SAB.

6.1 The local CQC inspector was sufficiently concerned about risk of tenants wandering at the scheme where Leocardo lived, that she carried out a focused inspection on this issue in July 2017, one month before his death. The care provider's concerns in relation to Leocardo, about the unsuitability of the door entry system and his further and increasingly dangerous wandering, triggered the inspection.

6.2 The regulator also accurately assessed the care provider to be without any levers in the form of escalation mechanisms to move beyond repeated emails to the local authority setting out their increasing and well-founded concerns about Leocardo. The responsiveness to the care provider's concerns by the Council was addressed in the local authority report post-inquest: "*The Council did not respond to the provider's concerns generally, but particularly in the last two weeks prior to Leocardo going missing for the final time".*

6.3 The methodology of the Care Quality Commission's July 2017 focused inspection was to carry out a study of five case files of tenants at the scheme, excluding Leocardo's, where they had concerns about similar risks. "We carried out an unannounced comprehensive inspection of this service on 4 July 2017. At which a breach of legal requirements was found. This related to how the service managed risks to people. ... we found that risks to people's health and safety were not safely managed". This quotation is taken from the next inspection report of November 2017. In that next inspection [the CQC] "saw that some improvements had been made. However, further improvements were required to address the risks we identified where people may wander out of [the scheme]"[3].

[3] The care provider is not in agreement with the findings of the CQC in relation to this issue.

6.4 The audits commissioned by the Safeguarding Adults Board provide a time-specific assessment of how risk is managed in extra care schemes. Along with feedback from the intelligence-sharing meeting, and inspection reports by the Care Quality Commission about the care providers at the borough's extra care schemes, these provide the tools for the SAB to triangulate multi agency work with the regulator.

7.

What is the role of the landlord in the supported living model when risks are escalating?

Summary of the systems issues:

The inquest left an impression of a limited role for the landlord in the system when risks are escalating. Instead, the crucial time for their contribution to the system was said to be prior to an admission to extra care housing. This could be linked to a system deficit that was highlighted by the inquest – the lack of regular reviews by the local authority involving all relevant agencies. It also links to the underuse of the Mental Capacity Act as set out in sections 3 and 4 above. If reviews are happening and there is appropriate attention to Community Deprivation of Liberty Safeguards in extra care schemes, then the role of the landlord could be enhanced throughout the period of someone's tenancy and not just focused on pre-admission. The inquest also included a number of examples of witnesses suggesting that a certain task was not their responsibility which may indicate an unsafe system, and this included the landlord.

7.1 The landlord told the Coroner their duties were tenancy management, income management, repairs, health and safety, dealing with anti-social behaviour and managing a team of six scheme managers, and "we wouldn't necessarily be informed of a review'". In the interim SAR I picked up on the issue of reassessment, and said "Brent SAB could explore what was meant on 9th June 2015 by the local authority's conclusion that "Leocardo does not have capacity in relation to where he lives / care needs", yet without any apparent updated assessment, it is not clear from the chronologies how later assessments of capacity were made and in turn connected to escalating risk". In an improved system of reassessment there should be a role for the landlord in relevant cases.

7.2 The inquest and follow on report from Brent Council included a number of examples of assertions that a certain task was not that of one organisation, but that of another party to the inquest. In the Head of Complex Care's report to the Lead Member for adult social care. "…There was no need for commissioning to be involved as this would have needed to be put in place by the

housing provider. The care provider could, and should have been made responsible for liaising with the housing provider to get the door alarm fitted, with the role of the ASW being to check and assure this had been done." At best this suggests a gap in understanding. Addressing it could form part of the strategy to ensure that the escalating numbers of people with dementia within the borough are able to live their lives free from abuse and neglect**.** In addition, those examples may suggest a culture of unhelpful relationships between organisations who have to deliver the strategy. Culture is harder to quantify and address - but is something the SAB could properly ask for assurance on, maybe as a next development of the audits it has already commissioned. These two issues are followed up in the recommendations.

7.3 The inquest heard about differing opinions, not resolved at the time, on whether Leocardo was ever a suitable tenant for the extra care scheme in 2015 when the council nominated him for a tenancy there. The landlord included for the Coroner an email from that time, in which one of its employees stated that Leocardo was never going to be safe there due to his wandering. In terms of what makes a safe system - understanding risks ahead of offering a tenancy is a multi-agency responsibility. The inquest clarified the current role of the landlord. Leocardo moved to the scheme at the point it opened, and with 40 flats to fill in one go, procedures were different. Now the care provider assesses a potential tenant first. Only once they are content does the landlord carry out their assessment and additionally, they have sight, as reported by the Head of Complex Care to the Lead Member, of *"an extra care checklist for front line workers to use, prior to nominating an individual for extra care, which asks for consideration of any risks, particularly wandering was put in place as part of the initial review completed by ASC".*

7.4 The possibility that sensors over Leocardo's flat door were not working at the time he went missing emerged during the inquest. The Coroner noted a possible role for the regulator and the landlord on this issue but placed the main responsibility with the care provider. The recommendations pick up on these responsibilities and how they could be developed and assured by Brent SAB.

Section Two

For each of these three areas I have suggested a set of recommendations, mainly multi-agency but including where appropriate single agency issues that the review or inquest picked up.

For completeness, I have referenced the seven overarching questions from the Terms of Reference for this review and how they fit with the Recommendations.

A**ssurance area 1:**

Developing a strategy to ensure that the escalating numbers of people with dementia within the borough are able to live their lives free from abuse and neglect.

Relates to the following 'overarching questions' from the Terms of Reference

1.How well does the local safeguarding system respond to the needs of adults whose risk and vulnerability is increasing? Where possible comment on the effectiveness of Reactive systems, for example: MERLINs, Safeguarding Referrals, Missing Person alerts and Proactive systems, for example: contract monitoring and care reviews.

2. What is the ability of professionals to respond in a timely and proportionate manner that also understands the role of families in these situations? Where possible, comment on the added complexity when family members hold the legal authority to make decisions.

5. What is the current rationale behind use of either residential care or extra care housing for older people with dementia? In both types of settings, is there learning that could be applied to commissioning of appropriate levels of support for tenants (extra care housing) or: residents (care home settings) that is not static but is dynamic and has implications for everyone who lives in that setting, as well as the professionals providing the services.

The Recommendations

Agency / SAB	**Recommendation**
Brent SAB	**Issue:** The Met-wide system for finding adults with dementia who go missing does not appear to join up every missing report with the result that opportunities to assess risk and locate adults with dementia are not as consistently effective as they could be

	Action: Brent SAB should seek assurance via the London Safeguarding Adults Board and the London Chairs Network on whether the police evidence to the inquest represents consistent or current practice. The Met Police monthly Safeguarding Adults Report data shared with Safeguarding Adults Boards and broken down by borough is focused on mental health and reports of abuse and neglect and does not cover adults with care and support needs who go missing. Police colleagues have historically been keen to engage SABs on how to make this data most useful. It would be timely to ask about their ability to extract and share data on adults with dementia who go missing in case it can help reduce the likelihood across London of what happened to Leocardo being repeated.
West Borough Operational Command Unit of the Metropolitan Police	**Issue:** For the family there was a particular issue that was outside of the scope of the inquest, but which Brent SAB set out to respond to as part of this review. This was the insensitive handling of the discovery of Leocardo's body by the police. The statement by Leocardo's daughter set out unequivocally the impact this had on the family. **Action:** A written response should be sought for Leocardo's family copied to the independent chair of Hillingdon Safeguarding Adults Board for courtesy and in case it raises any further issues in that borough.
Brent SAB	**Issue:** Attorneyship and decision-making on whether to deprive someone of their liberty poses dilemmas for families and professionals. Knowledge and information is essential for both. Culture change around the quality of social work practice in the local authority in order to equip professionals is already under way but needs testing out. **Action:** Brent SAB to ask for an update from the local authority on the impact of two training courses set up in response to Leocardo's case - a specific training course for social workers

	addressing LPA and DoLS, and a course addressing LPA and managing tenancy which has since been added to the Skills Academy programme. **Action:** Brent SAB to explore whether the Office of the Public Guardian's 'LPA Partners' Programme is an opportunity to use OPPG resources and Brent local knowledge to provide information to families in Brent about the scope and limitations of their power in relation to Deprivation of Liberty.
London Borough of Brent	**Issue:** In response to Leocardo's case, the local authority addressed the lack of understanding about roles and escalation when risk in extra care housing was unaddressed. This was by means of organisational change so that people who have been placed in extra care housing by a social worker are not managed by a social worker from the Complex Care Team but they instead have a Placement Review Officer, who is the named worker for all individuals in that home or scheme. **Action:** Brent SAB to ask for a report on generally how this is working, and specifically how this might be affecting the referrals of safeguarding concerns from extra care housing providers.
Brent SAB	**Issue:** Although there are a number of developments, all covered by recommendations in this section, taken together they do not answer the question "What is the current rationale behind use of either residential care or extra care housing for older people with dementia?" In both types of settings, is there learning that could be applied to commissioning of appropriate levels of support for tenants (extra care housing) or residents (care home settings) that is not static but is dynamic and has implications for everyone who lives in that setting, as well as the professionals providing the services. **Action:** Brent SAB to ask for a report on this from the local authority, perhaps linked to the scheduled update report on the *New Accommodation for Independent Living* Programme to Brent's Cabinet in September 2020; and additionally covering

	the issue of whether professionals could at times have an unhelpful bias against residential care due to the benefits of extra care as it has been developed in Brent. The report would cover demographics as highlighted in section 5.
London Borough of Brent	**Issue:** The Coroner said that the local authority duty to keep Leocardo safe outweighed the importance of balancing this with the wishes of his family who held Lasting Power of Attorney. This is a departure from what case law has set out. **Action:** The local authority should seek an update from their legal adviser on any case law that tests this 'weighting' further.

Assurance area 2:

Reduce the risks to individuals whilst appropriately maintaining the balance of care vs control.

Relates to the following 'overarching questions' from the Terms of Reference

3. How does the adult safeguarding and care management system in Brent understand, and support the application of, the Mental Capacity Act? What weight is given to this in comparison to all the other competing factors in the system?

4. How well do professionals in all relevant settings apply and understand the Mental Capacity Act in LB Brent?

The Recommendations

Agency / SAB	**Recommendation**
Brent SAB	**Issue:** two audits commissioned by the SAB found positive practice in relation to risk and adults with dementia in extra care housing but also some areas for improvement.
Brent SAB	**Issue:** One of the two documented Best Interests assessments for Leocardo was by the GP he registered with at the extra care scheme. A safe system is one where other agencies routinely involve the GP in Mental Capacity discussions. Additionally the inquest included examples of witnesses suggesting that a certain task was not their responsibility, but that of another

	organisation. This could be tested out in relation to Mental Capacity assessment referrals. **Action:** A next round of the SAB audits on extra care and risk assessment to pick this up.
London Borough of Brent	**Issue:** Leocardo's case highlighted the need for cultural change within social work practice in order to address shortcomings around application of the Mental Capacity Act, Best Interests and Deprivation of Liberty Safeguards including Community DoLs. A range of initiatives were immediately introduced by the local authority and there have been further developments – the impact now needs to be assessed and reported. **Action:** The local authority to assess the cumulative impact of their work to change culture around MCA. A report to the SAB should include the following positive developments • An experienced and qualified Safeguarding Adults Manager is now in a dedicated DoLS oversight post and maintains an overview of the process as well as providing advice and guidance for staff around the DoLS process • *A qualified and experienced social worker has been recruited into the Supported Living Commissioning service (started on the 5th November) specifically to work on community DOLS within Extra Care Schemes and training is being arranged for all staff for community DOLS.* • *In preparation for the implementation of the new Liberty Protection Safeguards, a review of the DOLS process was commissioned in Jan 2019, and an external consultant supported us to redesign the process and forms on mosaic. This went live with training for all staff in July 2019."*
London Borough of Brent	**Issue:** There is innovation and good practice in Brent which should be shared locally and nationally. In response to

	Leocardo's case, the local authority agreed a pilot scheme to support individuals with challenging behaviours to access the community through employing a Community Access worker. **Action:** As the impact of this work is demonstrated, to share as appropriate.

Assurance area 3:

Make suggestions as to where joint working should be improved to ensure a multi-agency approach to safeguarding high risk individuals.

Relates to the following 'overarching questions' from the Terms of Reference

6. Is there any learning in terms of how local organisations work with the regulator (CQC) in supported living / extra care / people receiving care in their own homes?
7. What is the role of the landlord in the supported living model when risks are escalating?

The Recommendations

Agency / SAB	**Recommendation**
The care provider at the extra care scheme	**Issue:** It emerged during the inquest that the testing of sensors for individual flat doors to make sure they are working needs to be done regularly and documented, if the activation of the sensor is part of a tenant's agreed risk management plan. **Action:** The care provider at the extra care scheme to update the SAB on the organisation's response, as part of this assurance area.
Brent SAB	**Issue:** The tools exist for effective multi-agency risk assessment working with the regulator in relation to extra care sheltered housing in Brent. These are: the monthly intelligence-sharing meeting between the Care Quality Commission, the NHS Clinical Commissioning Group and the local authority; audits such as those commissioned by the SAB; and the Care Quality Commission's inspection process. However, there may be times when these do not work as effectively as they usually do.

	Organisational change or operational pressures due to the Covid 19 pandemic are examples of what might affect this system. Understanding what causes difficulties with these three mechanisms, and the implications of the oversight not working as well as it does at its best, is the task of Brent Safeguarding Adults Board. **Action:** Brent SAB to agree and implement the most proportionate way of testing out the effectiveness of multi-agency oversight work with the regulator is working.
The Housing Provider	**Issue:** the inquest illustrated that historically the landlord of Leocardo's scheme had only been really involved in multi-agency discussion at the point an adult was assessed as a possible tenant of an extra care scheme. Reviews are a way to extend this involvement. **Action:** building on the audits which suggest good involvement of the landlord, and processes introduced by the local authority and reported to their Lead Member, the housing provider to write to the SAB with their reflections on how they can contribute to the multi-agency system beyond the earliest stage of someone's extra care tenancy.
London Borough of Brent and the care provider at the extra care scheme	**Issue:** The care provider's concerns in relation to Leocardo, about the unsuitability of the door entry system and his further and increasingly dangerous wandering, were the trigger for the CQC inspection of July 2020. When asked at the inquest, the social worker was unaware of the regulator's concerns about the doors. **Action:** The local authority and the care provider to update the SAB on their organisational expectation on who, especially in the new system of Placement Relationship Officers, needs to keep the other informed of provider notifications to the CQC.

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